

Chapter 4.5
Division of Workers' Compensation
Subchapter 1
Administrative Director-Administrative Rules

Article 1.1
Workers' Compensation Information System

9701. Definitions

The following definitions apply in this article:

(a) Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.

(b) California EDI Implementation Guide for First and Subsequent Reports of Injury. California EDI Implementation Guide, Version 2.1, dated ~~June~~ December 2005, contains California specific reporting requirements and information excerpted from the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. The California EDI Implementation Guide for First and Subsequent Reports of Injury, Version 2.1, dated ~~June~~ December 2005, is posted on the Division's Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, will be made available by the Division of Workers' Compensation upon request, and is incorporated by reference.

(c) California EDI Implementation Guide for Medical Bill Payment Records. California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated ~~July~~ December 2005, contains the California-specific protocols ~~excerpted and excerpts~~ from the IAIABC EDI Implementation Guide for Medical Bill Payment Records, explains the technical design and functionality of the WCIS system, testing options for the trading partners, instructions regarding the data elements for medical billing, and copies of the required medical billing electronic forms. The California EDI Implementation Guide for Medical Bill Payment Records, Version 1.0, dated ~~July~~ December 2005, is posted on the Division's Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, will be made available by the Division of Workers' Compensation upon request, and is incorporated by reference.

~~(a)~~ (d) Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:

- (1) Employer's Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations §§ 14004-14005.

(2) Doctor's First Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations §§ 14006-14007.

(3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code § 5500 and Title 8, California Code of Regulations § 10408.

(4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code § 3209.3.

~~(b)~~ (e) Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, California Insurance Guarantee Association (CIGA), or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(f) Claims Administrator's Agents. Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors.

~~(h)~~ (g) Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.

(e) ~~(h)~~ (h) Data Elements. Information identified by data number (DN) and defined in the dictionary of the IAIABC EDI Implementation Guide, Release 1. ~~EDI Implementation Guide, Release 1, or the EDI Implementation Guide, Release 2.~~ Data elements set forth in Section 9702 must be transmitted on all claims, where applicable, as indicated in Section 9702. The data elements set forth in the IAIABC EDI Implementation Guide, Release 1 ~~EDI Implementation Guides~~ that are not enumerated in Section 9702 are optional and may, but need not be, submitted on any or all claims.

~~(d)~~ ~~(h)~~ (i) Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.

~~(e) EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued August 9, 1995, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 1, are hereby incorporated by reference.~~

~~(f) EDI Implementation Guide, Release 2. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 2, issued November 30, 1998, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 2, are hereby incorporated by reference.~~

~~(g) EDI Trading Partner Profile. The form, required to be completed by the claims administrator, which sets forth the conditions under which the trading of data elements is to take place. The EDI Trading Partner Profile [Form DWC-WCIS TP01 (Revised 4/99), entitled “Electronic Data Interchange Trading Partner Profile”], is hereby incorporated by reference.~~

~~(h) Reserved for future rulemaking upon issuance of the EDI Medical Bill/Payment Report Implementation Guide by the International Association of Industrial Accident Boards and Commissions.~~

~~(i) (j) Health Care Organization (“HCO”). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code Sections 4600.5 and 4600.6.~~

~~(i) (k) IAIABC EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 1, issued February 15, 2002, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 1, are linked to the Division’s Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, and are hereby incorporated by reference.~~

~~(i) (l) IAIABC EDI Implementation Guide for Medical Bill Payment Records. IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, approved July 4, 2002, by the International Association of Industrial Accident Boards and Commissions. Sections 1 through 3, and ~~6~~ 5 through 14 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1, are linked to the Division’s Web site at <http://www.dir.ca.gov/dwc/WCIS.htm>, and are incorporated by reference.~~

~~(i) (H) (m) Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.~~

~~(i) (m) (n) Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.~~

~~(k) Reserved.~~

~~(i) (n) (o) International Association of Industrial Accident Boards and Commissions (“IAIABC”). A professional association of workers’ compensation specialists, located at ~~1201 Wakarusa Drive, C 3, Lawrence, Kansas 66049~~ 5610 Medical Circle, Suite 14, Madison, Wisconsin 53711, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers’~~

compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner. ~~Users of these standards are advised to contact IAIABC regarding any applicable licensing arrangements.~~

~~(m)(e)~~ (p) WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

Authority: Sections 133, 138.6, and 138.7, Labor Code.

Reference: Section 138.6 and 138.7, Labor Code.

9702. Electronic Data Reporting

(a) Each claims administrator shall transmit data elements, by electronic data interchange in the manner set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in subdivisions (b), (c), (d) and (e) are taken from California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Claims administrators shall only transmit the data elements that are set forth in the California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records. Each transmission of data elements shall include appropriate header and trailer records as set forth in the applicable California EDI Implementation Guide for First and Subsequent Reports of Injury and the California EDI Implementation Guide for Medical Bill Payment Records.

~~(1) The Administrative Director, upon request, may grant a claims administrator a variance in reporting all or part of the data elements required pursuant to Subsections (b) and (d) of this section. Any variance granted by the Administrative Director under this subsection shall be set forth in writing. This variance shall be granted upon:~~

~~——— (A) a documented showing that compliance with the reporting deadlines set forth in Subsections (b) and (d) would cause undue hardship to the claims administrator; and~~

~~——— (B) submission of a plan, prior to the applicable deadline set forth in Subsection (b) and (d), documenting the means by which the claims administrator will ensure full compliance with the data reporting by January 1, 2001.~~

~~——— (2) "Undue hardship" means that compliance with the applicable reporting deadline would result in significant difficulty or expense for the claims administrator.~~

~~(3) A claims administrator which certifies that the data reporting deadline set forth in subdivision (b) cannot be met because a computer system critical to carry out its mission is not yet capable of sending, receiving, or calculating data that contains dates after December 31, 1999 shall be deemed to have shown undue hardship for the purposes of paragraph (1).~~

~~(4) The variance period for reporting data elements under Subsections (b) and (d) will end on December 31, 2000. A claims administrator granted a variance shall submit to the WCIS by January 1, 2001 all data that were required to be submitted under Subsections (b) and (d) during the variance period except for data that were not known to the claims administrator or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.~~

(1) The Administrative Director, upon written request, may grant a claims administrator either a partial or total variance in reporting all or part of the data elements required pursuant to subdivision (e) of this section. Any variance granted by the Administrative Director under this subdivision shall be set forth in writing.

(A) A partial variance requested on the basis that the claims administrator is unable to transmit some of the required data elements to the WCIS shall be granted for a six month period only if all of the following are shown:

(i) a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

(ii) a documented showing that any medical data elements transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ; and

(iii) submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(B) A partial variance requested on the basis that the claims administrator is unable to report some of the required data elements to the WCIS because the data elements are not available to the claims administrator or the claims administrator's agent shall be granted for a six month period only if all of the following are shown:

(i) a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

(ii) a documented showing that any medical data elements transmitted by the claims administrator or the claims administrator's agent to public or private research or statistical entities shall be reported by the claims administrator to the WCIS ;

(iii) a documented showing that the claims administrator will submit to the WCIS the medical data elements available to the claims administrator or the claims administrator's agents; and

(iv) submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within six months from the request.

(C) A total variance shall be granted for a twelve month period if all of the following are shown:

(i) a documented showing that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator;

(ii) a documented showing that the claims administrator has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims;

(iii) a documented showing that the claims administrator is unable to transmit medical data to public or private research or statistical entities; and

(iv) submission of a plan, prior to the applicable deadline set forth in subdivision (e), documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request.

(2) "Undue hardship" shall be determined based upon a review of the documentation submitted by the claims administrator. The documentation shall include: the claims administrator's total required expenses; the reporting cost per claim if transmitted in house; and the total cost per claim if reported by a vendor. The costs and expenses shall be itemized to reflect costs and expenses related to reporting the data elements listed in subdivision (e) only.

(3) The variance period for reporting data elements under subdivisions (e)(1)(A) and (B) shall not be extended. The variance period for reporting data elements under subdivision (e)(1)(C) may be extended for additional twelve month periods if the claims administrator resubmits a written request for a variance. A claims administrator granted a variance shall submit to the WCIS all data elements that were required to be submitted under subdivision (e) during the variance period except for data elements that were not known to the claims administrator, the claims administrator's agents, or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.

(b) ~~On and after March 1, 2000,~~ Each claims administrator shall submit to the WCIS on each claim, within five (5) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

DATA ELEMENT NAME	DN
MAINTENANCE TYPE CODE	2
MAINTENANCE TYPE CODE DATE	3
JURISDICTION CODE (1)	4
INSURER FEIN	6
INSURER NAME	7
THIRD PARTY ADMINISTRATOR FEIN (2)	8
THIRD PARTY ADMINISTRATOR NAME (2)	9
CLAIM ADMINISTRATOR MAILING PRIMARY ADDRESS (1) LINE 1	10
CLAIM ADMINISTRATOR MAILING SECONDARY ADDRESS (1) LINE 2	11
CLAIM ADMINISTRATOR MAILING CITY (1)	12
CLAIM ADMINISTRATOR MAILING STATE CODE (1)	13
CLAIM ADMINISTRATOR MAILING POSTAL CODE (1)	14
CLAIM ADMINISTRATOR CLAIM NUMBER	15
EMPLOYER FEIN (3)	16
EMPLOYER NAME	18
EMPLOYER PHYSICAL PRIMARY ADDRESS (1) LINE 1	19
EMPLOYER PHYSICAL SECONDARY ADDRESS (1) LINE 2	20
EMPLOYER PHYSICAL CITY (1)	21
EMPLOYER PHYSICAL STATE CODE (1)	22
EMPLOYER PHYSICAL POSTAL CODE (1)	23
SELF INSURED INDICATOR (4)	24
DATE OF INJURY	31
ACCIDENT SITE POSTAL CODE (1) OF INJURY SITE	33
NATURE OF INJURY CODE	35
PART OF BODY INJURED CODE	36
CAUSE OF INJURY CODE	37
ACCIDENT/INJURY DESCRIPTION NARRATIVE (1)/CAUSE	38
DATE REPORTED TO EMPLOYER HAD KNOWLEDGE OF THE INJURY (1)	40
DATE REPORTED TO CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY (1)	41
EMPLOYEE SSN (1) (5) SOCIAL SECURITY NUMBER (1)	42
EMPLOYEE LAST NAME	43
EMPLOYEE FIRST NAME	44
EMPLOYEE MIDDLE NAME/INITIAL (1) (5)	45
EMPLOYEE MAILING PRIMARY ADDRESS LINE 1 (1) (5)	46
EMPLOYEE MAILING SECONDARY ADDRESS LINE 2 (1) (5)	47
EMPLOYEE MAILING CITY (1) (5)	48
EMPLOYEE MAILING STATE CODE (1) (5)	49
EMPLOYEE MAILING POSTAL CODE (1) (5)	50
EMPLOYEE PHONE NUMBER (1) (5)	51
EMPLOYEE DATE OF BIRTH	52
EMPLOYEE GENDER CODE (1)	53
EMPLOYEE MARITAL STATUS CODE (1) (6) (2)	54
EMPLOYEE NUMBER OF DEPENDENTS (1) (6) (2)	55
INITIAL DATE DISABILITY BEGAN (1)	56
EMPLOYEE DATE OF DEATH (6) (2)	57
EMPLOYMENT STATUS CODE (5) (1)	58
MANUAL CLASSIFICATION CODE (1) (7) (3)	59

OCCUPATION DESCRIPTION	60
EMPLOYEE DATE OF HIRE (1) (5)	61
AVERAGE WAGE (1) (5)	62
WAGE PERIOD CODE (1) (5)	63
INITIAL DATE LAST DAY WORKED (1)	65
SALARY CONTINUED IN LIEU OF COMPENSATION INDICATOR (1)	67
INITIAL DATE OF RETURN TO WORK DATE (1)	68
EMPLOYEE MAILING COUNTRY CODE (5) (8)	155
INSURED TYPE CODE (8)	184
CLAIM ADMINISTRATOR FEIN (8)	187
CLAIM ADMINISTRATOR NAME (8)	188
RETURN TO WORK TYPE CODE (8)	189
PHYSICAL RESTRICTIONS INDICATOR (8)	224
EMPLOYER UI NUMBER (3) (8)	329
<p>(1) Release 1 data element name differs.</p> <p>(2) Release 1 only ; not required for claims with a date of injury after July 1, 2000.</p> <p>(3) EMPLOYER FEIN (DN 16) and EMPLOYER UI NUMBER (DN 329) are substitutable; only one is required.</p> <p>(4) For Release 1 only; for Release 2 substitute INSURED TYPE CODE (DN 184).</p> <p>(5) (1) Required only when provided to the claims administrator.</p> <p>(6) (2) Death Cases Only.</p> <p>(7) (3) Required for insured claims only; optional for self insured claims.</p> <p>(8) For Release 2 only ; optional for claims with a date of injury before July 1, 2000.</p>	

DATA ELEMENT NAME	DN
<u>ACCIDENT DESCRIPTION /CAUSE</u>	<u>38</u>
<u>CAUSE OF INJURY CODE</u>	<u>37</u>
<u>CLAIM ADMINISTRATOR ADDRESS LINE 2</u>	<u>11</u>
<u>CLAIM ADMINISTRATOR ADDRESS LINE 1</u>	<u>10</u>
<u>CLAIM ADMINISTRATOR CITY</u>	<u>12</u>
<u>CLAIM ADMINISTRATOR CLAIM NUMBER</u>	<u>15</u>
<u>CLAIM ADMINISTRATOR POSTAL CODE</u>	<u>14</u>
<u>CLAIM ADMINISTRATOR STATE</u>	<u>13</u>
<u>CLASS CODE (3)</u>	<u>59</u>
<u>DATE DISABILITY BEGAN</u>	<u>56</u>
<u>DATE LAST DAY WORKED</u>	<u>65</u>
<u>DATE OF HIRE (1))</u>	<u>61</u>
<u>DATE OF INJURY</u>	<u>31</u>
<u>DATE OF RETURN TO WORK</u>	<u>68</u>
<u>DATE REPORTED TO CLAIM ADMINISTRATOR</u>	<u>41</u>
<u>DATE REPORTED TO EMPLOYER</u>	<u>40</u>
<u>EMPLOYEE ADDRESS LINE 1 (1)</u>	<u>46</u>
<u>EMPLOYEE ADDRESS LINE 2 (1)</u>	<u>47</u>
<u>EMPLOYEE CITY (1)</u>	<u>48</u>
<u>EMPLOYEE DATE OF BIRTH</u>	<u>52</u>
<u>EMPLOYEE DATE OF DEATH</u>	<u>57</u>
<u>EMPLOYEE FIRST NAME</u>	<u>44</u>
<u>EMPLOYEE LAST NAME</u>	<u>43</u>

<u>EMPLOYEE MIDDLE INITIAL (1)</u>	<u>45</u>
<u>EMPLOYEE PHONE (1)</u>	<u>51</u>
<u>EMPLOYEE POSTAL CODE (1)</u>	<u>50</u>
<u>EMPLOYEE STATE (1)</u>	<u>49</u>
<u>EMPLOYER ADDRESS LINE 1</u>	<u>19</u>
<u>EMPLOYER ADDRESS LINE 2</u>	<u>20</u>
<u>EMPLOYER CITY</u>	<u>21</u>
<u>EMPLOYER FEIN</u>	<u>16</u>
<u>EMPLOYER NAME</u>	<u>18</u>
<u>EMPLOYER POSTAL CODE</u>	<u>23</u>
<u>EMPLOYER STATE</u>	<u>22</u>
<u>EMPLOYMENT STATUS CODE (1)</u>	<u>58</u>
<u>GENDER CODE</u>	<u>53</u>
<u>INDUSTRY CODE</u>	<u>25</u>
<u>INSURER FEIN</u>	<u>6</u>
<u>INSURER NAME</u>	<u>7</u>
<u>JURISDICTION</u>	<u>4</u>
<u>MAINTENANCE TYPE CODE</u>	<u>2</u>
<u>MAINTENANCE TYPE CODE DATE</u>	<u>3</u>
<u>MARITAL STATUS CODE (2)</u>	<u>54</u>
<u>NATURE OF INJURY CODE</u>	<u>35</u>
<u>NUMBER OF DEPENDENTS (2)</u>	<u>55</u>
<u>OCCUPATION DESCRIPTION</u>	<u>60</u>
<u>PART OF BODY INJURED CODE</u>	<u>36</u>
<u>POSTAL CODE OF INJURY SITE</u>	<u>33</u>
<u>SALARY CONTINUED INDICATOR</u>	<u>67</u>
<u>SELF INSURED INDICATOR</u>	<u>24</u>
<u>SOCIAL SECURITY NUMBER (1)</u>	<u>42</u>
<u>THIRD PARTY ADMINISTRATOR FEIN</u>	<u>8</u>
<u>THIRD PARTY ADMINISTRATOR NAME</u>	<u>9</u>
<u>WAGE (1)</u>	<u>62</u>
<u>WAGE PERIOD (1)</u>	<u>63</u>
<u>(1) Required only when provided to the claims administrator.</u>	
<u>(2) Death Cases Only.</u>	
<u>(3) Required for insured claims only; optional for self-insured claims.</u>	

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

(c) Each transmission of data elements listed under (b), (d), (e), (f), or (g) of this section shall also include the following elements for data linkage:

<u>DATA ELEMENT NAME</u>	<u>DN</u>
<u>MAINTENANCE TYPE CODE (1)</u>	<u>2</u>
<u>MAINTENANCE TYPE CODE DATE (1)</u>	<u>3</u>
<u>JURISDICTION CLAIM NUMBER (1) (2) (3) (4)</u>	<u>5</u>
<u>INSURER FEIN (4)</u>	<u>6</u>

<u>THIRD PARTY ADMINISTRATOR FEIN (4)</u>	<u>8</u>
<u>CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4)</u>	<u>15</u>
<u>DATE OF INJURY (2)</u>	<u>31</u>
<u>EMPLOYEE SSN SOCIAL SECURITY NUMBER (2)(3)</u>	<u>42</u>
<p><u>(1) Maintenance Type Code (DN 2) and Maintenance Type Code Date (DN 3) are required for transmissions under Subsections (b), (d), (f), and (g).</u></p> <p><u>(1) (2) This number will be provided by WCIS upon receipt of the first report. The Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection.</u></p> <p><u>(2) (3) The Date of Injury (DN 31), Employee SSN (DN 42), and Claim Administrator Claim Number (DN 15) need not be submitted if the Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f).</u></p> <p><u>(4) If the Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).</u></p>	

<u>DATA ELEMENT NAME</u>	<u>DN</u>
<u>CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4)</u>	<u>15</u>
<u>DATE OF INJURY (2)</u>	<u>31</u>
<u>INSURER FEIN (4)</u>	<u>6</u>
<u>JURISDICTION CLAIM NUMBER (2) (3) (4)</u>	<u>5</u>
<u>MAINTENANCE TYPE CODE (1)</u>	<u>2</u>
<u>MAINTENANCE TYPE CODE DATE (1)</u>	<u>3</u>
<u>SOCIAL SECURITY NUMBER (2)(3)</u>	<u>42</u>
<u>THIRD PARTY ADMINISTRATOR FEIN (4)</u>	<u>8</u>
<p><u>(1) Maintenance Type Code (DN 2) and Maintenance Type Code Date (DN 3) are required for transmissions under Subsections (b), (d), (f), and (g).</u></p> <p><u>(2) This number will be provided by WCIS upon receipt of the first report. The Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection.</u></p> <p><u>(3) The Date of Injury (DN 31), Employee SSN (DN 42), and Claim Administrator Claim Number (DN 15) need not be submitted if the Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f).</u></p> <p><u>(4) If the Jurisdiction Claim Number (DN 5) is not provided, trading partners must provide the Claim Administrator Claim Number (DN 15) and the Third Party Administrator FEIN (DN 8), or, if there is no third party administrator, the Insurer FEIN (DN 6).</u></p>	

(d) ~~On and after July 1, 2000, e~~Each claims administrator shall submit to the WCIS within ~~ten (10)~~ fifteen (15) business days the following data elements, whenever

indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

DATA ELEMENT NAME	DN
DATE DISABILITY BEGAN	56
EMPLOYMENT STATUS CODE	58
AVERAGE WAGE (1)	62
WAGE PERIOD CODE (1)	63
INITIAL DATE OF RETURN TO WORK DATE (1)	68
DATE OF MAXIMUM MEDICAL IMPROVEMENT	70
CURRENT RETURN TO WORK DATE (1) DATE OF RETURN TO WORK/ RELEASE TO WORK	72
CLAIM STATUS CODE (1)	73
DATE CLAIM ADMINISTRATOR NOTIFIED OF EMPLOYEE REPRESENTATION (1)	76
LATE REASON CODE	77
PERMANENT IMPAIRMENT BODY PART CODE (1) (2) (3)	83
PERMANENT IMPAIRMENT PERCENTAGE (1) (3) (2)	84
BENEFIT TYPE CODE (1) PAYMENT/ADJUSTMENT CODE	85
BENEFIT TYPE AMOUNT PAID (1) PAYMENT/ADJUSTMENT PAID TO DATE	86
PAYMENT/ADJUSTMENT WEEKLY AMOUNT	87
BENEFIT PERIOD PAYMENT/ADJUSTMENT START DATE (1)	88
BENEFIT PERIOD THROUGH PAYMENT/ADJUSTMENT END DATE (1)	89
PAYMENT/ADJUSTMENT WEEKS PAID	90
PAYMENT/ADJUSTMENT DAYS PAID	91
BENEFIT ADJUSTMENT CODE	92
BENEFIT ADJUSTMENT WEEKLY AMOUNT (1)	93
BENEFIT ADJUSTMENT START DATE	94
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE	95
BENEFIT ADJUSTMENT END DATE	125
BENEFIT CREDIT CODE	126
BENEFIT CREDIT START DATE	127
BENEFIT CREDIT END DATE	128
BENEFIT CREDIT WEEKLY AMOUNT	129
CURRENT DATE DISABILITY BEGAN	144
CURRENT DATE LAST DAY WORKED	145
DEATH RESULT OF INJURY CODE	146
DENIAL REASON CODE	173
GROSS WEEKLY AMOUNT	174
RETURN TO WORK TYPE CODE	189
OTHER BENEFIT TYPE AMOUNT (4)	215
OTHER BENEFIT TYPE CODE (4)	216
PHYSICAL RESTRICTIONS INDICATOR	224

RETURNED TO WORK WITH SAME EMPLOYER INDICATOR	228
DENIAL EFFECTIVE DATE	240
(1) Release 1 data element name differs. (2) (1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments. (3) (2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq. (4) Only for Other Benefit Type Codes 310 (Total Penalties) and 321 (Total Employee Interest).	

DATA ELEMENT NAME	DN
<u>CLAIM STATUS</u>	<u>73</u>
<u>DATE DISABILITY BEGAN</u>	<u>56</u>
<u>DATE OF MAXIMUM MEDICAL IMPROVEMENT</u>	<u>70</u>
<u>DATE OF REPRESENTATION</u>	<u>76</u>
<u>DATE OF RETURN TO WORK</u>	<u>68</u>
<u>DATE OF RETURN TO WORK/ RELEASE TO WORK</u>	<u>72</u>
<u>EMPLOYMENT STATUS CODE</u>	<u>58</u>
<u>LATE REASON CODE</u>	<u>77</u>
<u>PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT</u>	<u>96</u>
<u>PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE</u>	<u>95</u>
<u>PAYMENT/ADJUSTMENT CODE</u>	<u>85</u>
<u>PAYMENT/ADJUSTMENT DAYS PAID</u>	<u>91</u>
<u>PAYMENT/ADJUSTMENT END DATE</u>	<u>89</u>
<u>PAYMENT/ADJUSTMENT PAID TO DATE</u>	<u>86</u>
<u>PAYMENT/ADJUSTMENT START DATE</u>	<u>88</u>
<u>PAYMENT/ADJUSTMENT WEEKLY AMOUNT</u>	<u>87</u>
<u>PAYMENT/ADJUSTMENT WEEKS PAID</u>	<u>90</u>
<u>PERMANENT IMPAIRMENT BODY PART CODE (1) (2)</u>	<u>83</u>
<u>PERMANENT IMPAIRMENT PERCENTAGE (2)</u>	<u>84</u>
<u>WAGE</u>	<u>62</u>
<u>WAGE PERIOD</u>	<u>63</u>
<u>(1) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.</u> <u>(2) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases and stipulated settlements, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq.</u>	

Note: Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical only claims, the final report would be reported under Subsection (g) (MTC = AN) with claim status = “closed.”

(e) Reserved for future rulemaking requiring the submission of medical bill/payment reports. On and after June 1, 2006, (OAL TO INSERT A DATE 6 MONTHS AFTER THE DATE OF FILING WITH SECRETARY OF STATE

HERE), claims administrators handling one hundred and fifty (150) or more total claims per year shall submit to the WCIS on each claim with a date of service on or after ~~June 1, 2006~~ **(OAL TO INSERT A DATE 6 MONTHS AFTER THE DATE OF FILING WITH SECRETARY OF STATE HERE)**, the following data elements for all medical services for which the claims administrator has received a billing or other report of provided medical services. The California EDI Implementation Guide for Medical Bill Payment Records sets forth the specific California reporting requirements. The data elements required in this subdivision are taken from California EDI Implementation Guide for Medical Bill Payment Records and the IAIABC EDI Implementation Guide for Medical Bill Payment Records. The claims administrator shall submit the data within ninety (90) calendar days of the medical bill payment. Each claims administrator shall transmit the data elements by electronic data interchange in the manner set forth in the California EDI Implementation Guide for ~~First and Subsequent Reports of Injury for~~ Medical Bill Payment Records.

<u>DATA ELEMENT NAME</u>	<u>DN</u>
<u>ACKNOWLEDGMENT TRANSACTION SET ID</u>	<u>110</u>
<u>ADMISSION DATE</u>	<u>513</u>
<u>ADMITTING DIAGNOSIS CODE</u>	<u>535</u>
<u>APPLICATION ACKNOWLEDGMENT CODE</u>	<u>111</u>
<u>BASIS OF COST DETERMINATION CODE</u>	<u>564</u>
<u>BATCH CONTROL NUMBER</u>	<u>532</u>
<u>BILL ADJUSTMENT AMOUNT</u>	<u>545</u>
<u>BILL ADJUSTMENT GROUP CODE (2)(7) (5)</u>	<u>543</u>
<u>BILL ADJUSTMENT REASON CODE (2)(8)</u>	<u>544</u>
<u>BILL ADJUSTMENT UNITS</u>	<u>546</u>
<u>BILL SUBMISSION REASON CODE (5)</u>	<u>508</u>
<u>BILLING FORMAT CODE</u>	<u>503</u>
<u>BILLING PROVIDER FEIN</u>	<u>629</u>
<u>BILLING PROVIDER LAST/GROUP NAME</u>	<u>528</u>
<u>BILLING PROVIDER POSTAL CODE</u>	<u>542</u>
<u>BILLING PROVIDER PRIMARY SPECIALTY CODE (6)(4)</u>	<u>537</u>
<u>BILLING PROVIDER STATE LICENSE NUMBER (6) (4)</u>	<u>630</u>
<u>BILLING PROVIDER UNIQUE BILL IDENTIFICATION NUMBER</u>	<u>523</u>
<u>BILLING TYPE CODE</u>	<u>502</u>
<u>CLAIM ADMINISTRATOR CLAIM NUMBER</u>	<u>15</u>
<u>CLAIM ADMINISTRATOR FEIN</u>	<u>187</u>
<u>CLAIM ADMINISTRATOR NAME</u>	<u>188</u>
<u>CONTRACT TYPE CODE</u>	<u>515</u>
<u>DATE INSURER PAID BILL (2)</u>	<u>512</u>
<u>DATE INSURER RECEIVED BILL</u>	<u>511</u>
<u>DATE OF BILL</u>	<u>510</u>
<u>DATE OF INJURY</u>	<u>31</u>
<u>DATE PROCESSED</u>	<u>108</u>
<u>DATE TRANSMISSION SENT</u>	<u>100</u>
<u>DAYS/UNITS BILLED</u>	<u>554</u>
<u>DAYS/UNITS CODE</u>	<u>553</u>
<u>DIAGNOSIS POINTER</u>	<u>557</u>

<u>DISCHARGE DATE</u>	<u>514</u>
<u>DISPENSE AS WRITTEN CODE</u>	<u>562</u>
<u>DME BILLING FREQUENCY CODE</u>	<u>567</u>
<u>DRG CODE</u>	<u>518</u>
<u>DRUG NAME</u>	<u>563</u>
<u>DRUGS/SUPPLIES BILLED AMOUNT</u>	<u>572</u>
<u>DRUGS/SUPPLIES DISPENSING FEE</u>	<u>579</u>
<u>DRUGS/SUPPLIES NUMBER OF DAYS</u>	<u>571</u>
<u>DRUGS/SUPPLIES QUANTITY DISPENSED</u>	<u>570</u>
<u>ELEMENT ERROR NUMBER</u>	<u>116</u>
<u>ELEMENT NUMBER</u>	<u>115</u>
<u>EMPLOYEE FIRST NAME</u>	<u>44</u>
<u>EMPLOYEE LAST NAME</u>	<u>43</u>
<u>EMPLOYEE MIDDLE NAME/INITIAL</u>	<u>45</u>
<u>EMPLOYEE EMPLOYMENT VISA</u>	<u>152</u>
<u>EMPLOYEE GREEN CARD</u>	<u>153</u>
<u>EMPLOYEE PASSPORT NUMBER</u>	<u>156</u>
<u>EMPLOYEE SOCIAL SECURITY NUMBER</u>	<u>42</u>
<u>FACILITY CODE</u>	<u>504</u>
<u>FACILITY FEIN</u>	<u>679</u>
<u>FACILITY MEDICARE NUMBER</u>	<u>681</u>
<u>FACILITY NAME</u>	<u>678</u>
<u>FACILITY POSTAL CODE</u>	<u>688</u>
<u>FACILITY STATE LICENSE NUMBER</u>	<u>680</u>
<u>HCPCS BILL PROCEDURE CODE</u>	<u>737</u>
<u>HCPCS LINE PROCEDURE BILLED CODE</u>	<u>714</u>
<u>HCPCS LINE PROCEDURE PAID CODE</u>	<u>726</u>
<u>HCPCS MODIFIER BILLED CODE</u>	<u>717</u>
<u>HCPCS MODIFIER PAID CODE</u>	<u>727</u>
<u>HCPCS PRINCIPLE PROCEDURE BILLED CODE</u>	<u>626</u>
<u>ICD-9 CM DIAGNOSIS CODE</u>	<u>522</u>
<u>ICD-9 CM PRINCIPAL PROCEDURE CODE</u>	<u>525</u>
<u>ICD-9 CM PROCEDURE CODE</u>	<u>736</u>
<u>INSURER FEIN</u>	<u>6</u>
<u>INSURER NAME</u>	<u>7</u>
<u>INTERCHANGE VERSION ID</u>	<u>105</u>
<u>JURISDICTION CLAIM NUMBER</u>	<u>5</u>
<u>JURISDICTION MODIFIER BILLED CODE (8)(10)(11)(12)(13)</u>	<u>718</u>
<u>JURISDICTION MODIFIER PAID CODE (11) (8)</u>	<u>730</u>
<u>JURISDICTION PROCEDURE BILLED CODE (11) (8)</u>	<u>715</u>
<u>JURISDICTION PROCEDURE PAID CODE (11) (8)(9)</u>	<u>729</u>
<u>LINE NUMBER</u>	<u>547</u>
<u>MANAGED CARE ORGANIZATION FEIN (1)</u>	<u>704</u>
<u>MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER</u>	<u>208</u>
<u>MANAGED CARE ORGANIZATION NAME</u>	<u>209</u>
<u>MANAGED CARE ORGANIZATION POSTAL CODE</u>	<u>712</u>
<u>NDC BILLED CODE</u>	<u>721</u>
<u>NDC PAID CODE</u>	<u>728</u>
<u>ORIGINAL TRANSMISSION DATE</u>	<u>102</u>
<u>ORIGINAL TRANSMISSION TIME</u>	<u>103</u>
<u>PLACE OF SERVICE BILL CODE</u>	<u>555</u>
<u>PLACE OF SERVICE LINE CODE</u>	<u>600</u>

<u>PRESCRIPTION BILL DATE</u>	<u>527</u>
<u>PRESCRIPTION LINE DATE</u>	<u>604</u>
<u>PRESCRIPTION LINE NUMBER</u>	<u>561</u>
<u>PRINCIPLE DIAGNOSIS CODE</u>	<u>521</u>
<u>PRINCIPLE PROCEDURE DATE</u>	<u>550</u>
<u>PROCEDURE DATE</u>	<u>524</u>
<u>PROVIDER AGREEMENT CODE (4) (3)</u>	<u>507</u>
<u>RECEIVER ID</u>	<u>99</u>
<u>RELEASE OF INFORMATION CODE</u>	<u>526</u>
<u>RENDERING BILL PROVIDER FEIN</u>	<u>642</u>
<u>RENDERING BILL PROVIDER LAST/GROUP NAME</u>	<u>638</u>
<u>RENDERING BILL PROVIDER POSTAL CODE</u>	<u>656</u>
<u>RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE</u>	<u>651</u>
<u>RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER</u>	<u>649</u>
<u>RENDERING BILL PROVIDER STATE LICENSE NUMBER</u>	<u>643</u>
<u>RENDERING LINE PROVIDER NATIONAL ID (9)(10) (7)</u>	<u>592</u>
<u>RENDERING LINE PROVIDER FEIN</u>	<u>586</u>
<u>RENDERING LINE PROVIDER LAST/GROUP NAME (9) (6)</u>	<u>589</u>
<u>RENDERING LINE PROVIDER POSTAL CODE</u>	<u>593</u>
<u>RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (9) (6)</u>	<u>595</u>
<u>RENDERING LINE PROVIDER STATE LICENSE NUMBER (9) (6)</u>	<u>599</u>
<u>REPORTING PERIOD</u>	<u>615</u>
<u>REVENUE BILLED CODE</u>	<u>559</u>
<u>REVENUE PAID CODE</u>	<u>576</u>
<u>SENDER ID</u>	<u>98</u>
<u>SERVICE ADJUSTMENT AMOUNT</u>	<u>733</u>
<u>SERVICE ADJUSTMENT GROUP CODE (2)(7) (5)</u>	<u>731</u>
<u>SERVICE ADJUSTMENT REASON CODE (2)(7)(8) (5)</u>	<u>732</u>
<u>SERVICE BILL DATE(S) RANGE</u>	<u>509</u>
<u>SERVICE LINE DATE(S) RANGE (8)</u>	<u>605</u>
<u>TEST/PRODUCTION INDICATOR</u>	<u>104</u>
<u>TIME PROCESSED</u>	<u>109</u>
<u>TIME TRANSMISSION SENT</u>	<u>101</u>
<u>TOTAL AMOUNT PAID PER BILL (2)(3)</u>	<u>516</u>
<u>TOTAL AMOUNT PAID PER LINE (2)(3)</u>	<u>574</u>
<u>TOTAL CHARGE PER BILL (2)</u>	<u>501</u>
<u>TOTAL CHARGE PER LINE - PURCHASE</u>	<u>566</u>
<u>TOTAL CHARGE PER LINE - RENTAL</u>	<u>565</u>
<u>TOTAL CHARGE PER LINE (2)</u>	<u>552</u>
<u>TRANSACTION TRACKING NUMBER</u>	<u>266</u>
<u>UNIQUE BILL ID NUMBER</u>	<u>500</u>
<u>(1) For HCO claims use the FEIN of the sponsoring organization in DN 704.</u>	
<u>(2) Not required when claims administrator provides medical services to injured workers on a capitated basis under Labor Code § 4614 (b).</u>	
<u>(3) (2) Not required if on non-denied bills if amount paid equals amount charged.</u>	
<u>(4) (3) For MPN claims use code P "Participation Agreement"</u>	
<u>(5) For medical services provided on a capitated basis under Labor Code § 4614 (b), use code 09 "Encounter."</u>	
<u>(6) (4) Does not apply if billing provider is an organization.</u>	

(7) (5) Required if charged and paid amounts differ.
(8) For reporting of medical lien payments, use code 64 "Denial reversed per medical review."
(9) (6) Optional if rendering provider equals billing provider.
(10) (7) To be provided following the assignment of a National Provider Identifier by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS"), Health Care Financing Administration ("HCFA").
(11) (8) The codes for this data element are the codes that are set forth in the California Official Medical Fee Schedule, a publication of the State of California, Department of Industrial Relations (adopted pursuant to Labor Code § 5307.1 and Title 8, California Code of Regulations § 9790 et seq.).
(12) (9) Optional if procedure billed equals procedure paid.
(13) (10) Use when a modifier has been provided.

(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, commencing in 2001, claims administrators shall, for each claim with a date of injury on or after July 1, 2000 and with any payment in any benefit category, including medical, in the previous calendar year, report the total paid in each payment category through the previous calendar year by submitting the following data elements:

<u>DATA ELEMENT NAME</u>	<u>DN</u>
BENEFIT TYPE CODE PAYMENT/ADJUSTMENT CODE	85
BENEFIT TYPE AMOUNT PAYMENT/ADJUSTMENT PAID TO DATE	86
PAYMENT/ADJUSTMENT START DATE	88
PAYMENT/ADJUSTMENT END DATE	89
OTHER BENEFIT TYPE AMOUNT	215
OTHER BENEFIT TYPE CODE	216
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT	96
PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE	95

<u>DATA ELEMENT NAME</u>	<u>DN</u>
<u>PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES AMOUNT</u>	<u>96</u>
<u>PAID TO DATE/ REDUCED EARNINGS/ RECOVERIES CODE</u>	<u>95</u>
<u>PAYMENT/ADJUSTMENT CODE</u>	<u>85</u>
<u>PAYMENT/ADJUSTMENT END DATE</u>	<u>89</u>
<u>PAYMENT/ADJUSTMENT PAID TO DATE</u>	<u>86</u>
<u>PAYMENT/ADJUSTMENT START DATE</u>	<u>88</u>

~~(h) Note:~~ Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report ~~would~~ may be reported under this ~~subsection or on the annual report~~ (MTC = AN) with claim status = "closed."

~~(h)~~ (i) (1) A claims administrator's obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code Section 138.4 is satisfied upon written determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under Subsection (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after ~~June 1, 2006~~ **QAL TO INSERT A DATE 6 MONTHS AFTER THE DATE OF FILING WITH SECRETARY OF STATE HERE**, a claims administrator's obligation to submit an Annual Report of Inventory pursuant to Title 8, California Code of Regulations, section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under subsections divisions (b), (d), (e), and (g), and continued compliance with those subsections.

~~(h)~~ (j) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee's employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in section 9703 and Labor Code section 138.7.

~~(h)~~ (k) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

Authority: Sections 133, 138.4, 138.6, and 138.7, Labor Code.

Reference: Section 138.4, 138.6, and 138.7, Labor Code.

9703. Access To Individually Identifiable Information

(a) No person shall have access to individually identifiable data held in the WCIS except as provided in this section and subdivision (c) of section 138.7 of the Labor Code.

(b) The Division of Workers' Compensation may obtain and use individually identifiable information for the following purposes:

- (1) To create and maintain the WCIS, including the selection of claims to survey in order to obtain information not available from the data elements provided by claims administrators.
- (2) To help select claims administrators for audits under section 129 of the Labor Code.
- (3) To report the promptness with which claims administrators make payments.
- (4) To electronically import names, addresses, and other information into Division of Workers' Compensation cases files which would otherwise have to be key entered by agency staff.
- (5) To conduct research related to the workers' compensation system for the purpose of carrying out the duties of the Division of Workers' Compensation or the Administrative Director.

(c) The following agencies may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director and the agency, for the purposes specified:

- (1) The Division of Occupational Safety and Health may use individually identifiable information to help select employers for health and safety consultations and inspections.
- (2) The Division of Labor Statistics and Research may use individually identifiable information to carry out its research and reporting responsibilities under Labor Code sections 150 and 156.
- (3) The Department of Health Services may use individually identifiable information to carry out its occupational health and occupational disease prevention responsibilities under section 105175 of the Health and Safety Code.

(d) Upon written request to the Administrative Director, researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation ~~agencies~~ (CHSWC) may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director, the commission, and the person or entity conducting research, for the purpose of bona fide statistical research.

- (1) Any request from the ~~commission~~ CHSWC for individually identifiable information under this subdivision shall include the identity of the person or entity conducting the research, the purpose of the research, the research protocol, the need for individually identifiable WCIS data, and an anticipated completion date for the research.
- (2) Researchers under contract to the ~~commission~~ CHSWC seeking individually identifiable WCIS data under this subdivision shall also submit to the Administrative Director written approval of the research protocol by an Institutional Review Board in the same manner as required under subdivision (e). If the researcher under contract to the CHSWC is the University of

California or a non profit educational institution, the researcher shall comply with the provisions of Civil Code section 1789.24(t).

(3) Individually identifiable information obtained under this subdivision shall not be disclosed to the members of the ~~commission~~ CHSWC.

(4) No individually identifiable information obtained by researchers under this subdivision may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained.

(5) Researchers obtaining individually identifiable information under this subdivision shall notify the Administrative Director when the research has been completed. Except as required by researchers subject to subdivision (f), wWithin 30 days thereafter, the ~~commission~~ CHSWC shall present evidence to the Administrative Director that the data collected has been modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

~~(d)~~ (e) Individually identifiable information may be provided to other persons or public or private entities for the purpose of bona fide statistical research which does not divulge individually identifiable information concerning any employee, employer, claims administrator, or any other person or entity. Any request for individually identifiable information for this purpose shall include the identity of the requester, the purpose of the research, the methods of research, and the need for individually identifiable WCIS data. The requester shall also submit written approval of the research protocol by an Institutional Review Board, under Title 45, Code of Federal Regulations, Part 46, Subpart A. "Approval" means a determination by the Institutional Review Board that the research protocol was reviewed and provides sufficient safeguards to ensure the confidentiality of individually identifiable information. Any agreement to permit use of the data shall be in writing between the requester and the Administrative Director. Note: The Division shall make available upon request a list of Institutional Review Boards known to the Division that have the authority to grant the required approval and that expressed willingness to review research proposals under this section.

(f) The University of California or any non profit educational institution conducting scientific research must comply with the provisions of Civil Code section 1798.24(t).

~~(e)~~ ~~(f)~~ (g) Each agreement or memorandum of understanding entered concerning the use of individually identifiable information by any agency, entity, or person shall specify the methods to be used to protect the information from unlawful disclosure, and shall include a warning to the receiving party that it is unlawful for any person who has received individually identifiable information from the Division of Workers' Compensation under this section to provide the information to any person who is not entitled to it under this section and Labor Code § 138.7.

~~(f)~~ ~~(g)~~ (h) Nothing in this section shall be construed to exempt from disclosure any public record contained in an individual's file once an Application for Adjudication has been filed with the Workers' Compensation Appeals Board. This includes any data from an individual's file that are converted to or stored in an electronic format for the purpose of case processing and tracking.

~~(g)~~ ~~(h)~~ (i) Nothing in this section shall be construed to exempt from disclosure WCIS data in a format that does not contain individually identifiable information.

Authority: Sections 127, 133, 138.4, 138.6, and 138.7, Labor Code.

Reference: Sections 129, 138.4, 138.6, and 138.7, Labor Code; and 1798.24, Civil Code.